

Fig. 1.—Pathological specimen hardened in formalin 7.5 x 9.0 cm.



Fig. 2.—Three days after surgery, showing location of tumor, and result of sliding skin graft. The area between the suture lines, subsequently sloughed away.



Fig. 3.—February 12, 1935, sixteen weeks after surgery—shows practically complete healing. Dark areas are scarlet red ointment.

was covered with the extension, with an exception of an area of 4.4 by 6.6 centimeters in the center of the same. This area was then covered with vaselin gauze; dressings were applied; a rubber dam was inserted through a stab puncture at the lower edge of the wound in the neck; a sponge was placed over the lower face and neck in the area where the largest graft was performed, and the entire area was tightly bandaged.

Pathological report of removed tumor mass: Basal cell epithelioma.

Progress notes: Uneventful convalescence in hospital for ten days. Use of hot oil (olive) compresses instituted, changed every three hours. At discharge, it became evident that graft transplants were due to fail, as slough and gangrene were already developing.

November 15, 1934: At point where drain tube was inserted, there has developed a definite epithelioma of almond-sized proportions. X-ray therapy instituted.

December 6, 1934: Head looks remarkable; drainage has ceased, and the new epithelioma has flattened down to level of skin.

December 18, 1934: For the past two weeks has been on urotropin, with some improvement. Has a good deal of general pain, especially right arm and leg

(always lies on these); first attempt to lie on her back, successful. Abdomen swollen considerably, but no fluid wave is present. Quite unable to palpate through the abdomen, but there is definite epigastric fullness, which probably is the liver enlarged. Prognosis, poor.

December 25, 1934: Continues poorly. The liver occupies the upper half of the abdomen. Edema of ankles and thighs is intense. The head meanwhile is healing wonderfully well.

January 2, 1935: No changes generally. Teeth have lost good deal of calcium, and have become sharp. Dentist to file teeth smooth.

January 16, 1935: Been running septic temperature for a week; coughing more. No change in general condition.

January 30, 1935: Temperature normal all week. Some relief at night with use of codein tablets. Still using urotropin; also bromids for nervousness.

February 5, 1935: Head practically recovered. Last x-ray treatment today.

February 12, 1935: Edema of both legs still intense; there is also some edema of the back; and a good deal of swelling in the right arm. Salyrgan 10 per cent, one-half cubic centimeter given intravenously.

March 15, 1935: Beginning signs of uremia, with anuria; muscular twitching, and lapse of memory.

March 17, 1935: Expired of uremic poisoning.

X-ray treatments were given this patient through the office of Doctors Ingber and Rodenbaugh of this city. The dosage and frequency of treatments was as follows: 3250 r-units in divided doses in eight weeks, using two ports 40 centimeters distance, 140 k. v., and copper filter.

490 Post Street.

BENIGN HYPERTROPHIC PROSTATE

REPORT OF CASE OF LONG STANDING PERSISTENT BLEEDING FOLLOWING TRANSURETHRAL RESECTION

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Eureka

A NUMBER of cases of moderate to massive hemorrhage immediately following transurethral resection are reported from time to time in the literature. The following case differs from these in that no unusual bleeding occurred immediately after resection, but that moderate to marked hematuria persisted for four months following resection, despite all efforts to stop the prostatic bleeding.

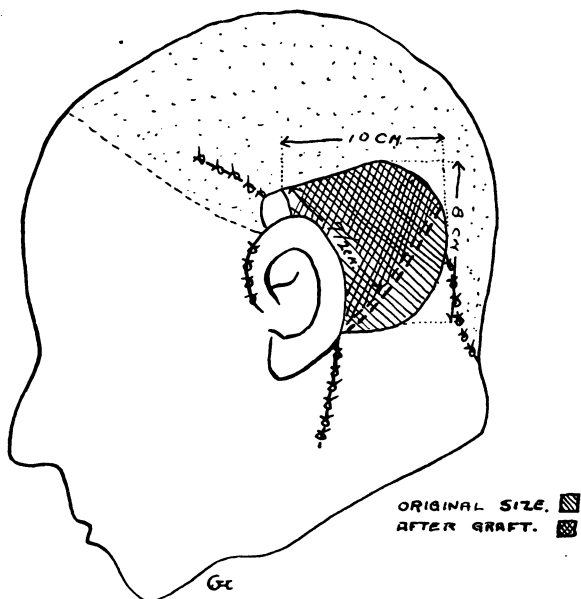


Fig. 4.—M. F.—48. Epithelioma scalp. Location and size of tumor before surgery and after sliding graft.

REPORT OF CASE

G. M., aged 58 years, married, white male, father of three children. Occupation, sheep rancher. Complaint: Frequency and difficulty of urination of two years' standing. General examination revealed a well-developed, well-preserved man, whose general appearance was the picture of health. Weight, 162 pounds. Height, 6 feet. There were no pathologic physical signs in any of the systems, with the exception of the lower urinary tract. Rectal touch indicated a prostate approximately four to five times normal size, symmetrical, moderately tender, and movable. On catheterizing the bladder after voiding, 75 cubic centimeters of residual urine was present. Urinalysis was as follows: Color, amber clear; no threads; reaction, faintly acid; specific gravity, 1012; albumin, negative; sugar, negative; microscopical, three to four pus cells per high dry field; no red cells; no casts. A cystourethroscopy was passed in the office and the intravesicular hypertrophy was observed. Considerable median lobe hypertrophy was noted, together with moderate lateral lobe enlargement. A diagnosis of benign hypertrophy was made and the case was considered a suitable one for transurethral resection. The patient was taken to the hospital and a vasectomy was done, following which the bladder was drained by way of the urethra by intermittent catheterization for a period of three days. A phenol red test at the time showed kidney function to be within normal limits. Under spinal anesthesia, with a McCarthy resectoscope and a Rose tube gap-cutting unit, six sections were removed from the median lobe, and three sections each from the two lateral lobes. All bleeding points were satisfactorily controlled by means of the coagulation current. A No. 30 French retention catheter was left in the bladder for two days. After this time the patient was allowed to void, and was dismissed from the hospital on the eighth postoperative day with no complaints and little or no residual urine. The pathologist's report on the sections removed were adenomatous hyperplasia of the prostate, with no evidence of malignancy.

The patient was seen biweekly, sometimes weekly, at the office for the next three and a half months. Three weeks postoperatively the patient stated that on two occasions, on arising in the morning, his urine appeared wine-colored or bloody, and at this time he brought a urine sample, which was grossly bloody. Urinalysis of a specimen voided at the office at this time was as follows: Color, smoky, with moderate amount of flakes; reaction, alkaline; specific gravity, 1015; albumin, one plus; microscopical, red blood cells full field; ten to fifteen pus cells per field. The bleeding was thought to be due to secondary infection, so the patient was irrigated twice weekly with 1:7000 potassium permanganate solution. He seemed to improve for a time, but after one month of such treatment his urine again became grossly bloody, so it was decided that some unusual condition existed at the site of resection. A McCarthy panendoscope was passed in the office, and the resected area was clearly observed. Several arteriolar bleeding points were noted, and these were subsequently fulgurated. Following this procedure the hematuria cleared for about ten days, only to recur the same as previously. During the next six weeks these bleeding areas were fulgurated on three different occasions, all without avail. It was then thought that some systemic condition was present. A Wassermann was taken, and returned negative. A platelet count showed the platelets to be normal in size and number. Clotting time was normal. A red blood count and hemoglobin estimation were as follows: hemoglobin, 70 per cent (Dare); red cells, 3,470,000. It was now clear that some other form of radical treatment was indicated, due to the patient's general condition. A prostatectomy was decided upon. The suprapubic route was selected, since the resected area could be better examined in this manner. The patient was taken to the hospital, where he was given 500 cubic centimeters of whole blood. The following day, under spinal anesthesia, a suprapubic prostatec-

tomy was performed. The prostate was enucleated without much difficulty, and the hemorrhage at the time was not considered excessive. Hemostasis was accomplished by means of a medium-sized Pilcher bag. On examination of the specimen, the "trough," which had previously been made with the resectoscope, was large enough to admit two fingers. In other words, there was no question that the obstruction had been absolutely removed. Healing at the site of resection was not complete and areas of punctate hemorrhage were discernible. The pathologist's report on the specimen was as before, namely, adenomatous hyperplasia.

The patient's convalescence was uneventful and he was discharged from the hospital on the fourteenth postoperative day with a rapidly closing suprapubic bladder fistula which closed entirely in twenty-two days from the date of operation. He was seen at the office four weeks postoperatively, at which time his urine was clear and showed five to six pus cells per high dry field and no red cells. He has been seen periodically for the past eighteen months and he had no complaints, and has gained several pounds in body weight.

COMMENT

1. This is a case in which a resection was done with a good anatomical, but a poor physiologic result.

2. This patient's bleeding, following resection, could be ascribed to no particular cause. The fact remains, however, that the patient was cured by prostatectomy.

3. The writer has reached no conclusion as to how to foresee or avoid the complication which arose in this case. He has seen too many good results following prostatic resection with the high frequency current, to conclude that the operation is an unsound surgical procedure.

507 F Street.

Foreign Protein in Treatment of Gonococcic Ophthalmia.—Hamilton treated two patients presenting adult gonococcic ophthalmia with injections of cow's milk boiled for four minutes and given intramuscularly into the buttocks on alternate days. Commencing with 10 cubic centimeters, he increased the dose rapidly to 25 cubic centimeters. Of numerous foreign proteins and serums, milk produces the best uniform rise in body temperature. The one risk of milk injections seems to be anaphylaxis. At the first indication of distress, 10 minims (0.6 cc.) of epinephrin should be given hypodermically. Patients in whom milk injections are definitely contraindicated are those who are weak and debilitated, especially marasmatic children, tuberculous patients, persons with kidney disease and women in the last months of pregnancy. The author's patients responded well to treatment. They show that high pyrexia is a definite aid in the treatment of adult gonococcic ophthalmia. The pyrexia must be continuous and maintained until all discharge ceases. If the patient becomes immune to one foreign protein, another must be substituted. The use of a 2 per cent silver nitrate solution, however useful in other forms of ophthalmia, is strongly contraindicated in the treatment of gonorrheal ophthalmia even in the later stages. In all cases of gonorrheal ophthalmia with corneal ulceration, the whole cornea should be covered with a conjunctival flap at once. A purse-string suture carefully inserted is the only sure method of keeping the conjunctival flap in place for the desired period, namely, ten days or longer. The author concludes that massive doses of foreign protein, given intramuscularly or intravenously on alternate days so that the body temperature is left swinging at a high level, are specific for gonococcic conjunctivitis in adults.—*Medical Journal of Australia.*